		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044909

Facility Name: Alden Park Strathmoor

Address: 5668 Strathmoor Drive (Number) Rockford (City) 61107 (Zip Code)

County: Winnebago

Telephone Number: (815) 229-5200 **Fax #** (773) 286-3743

IDPA ID Number: 36-4367439

Date of Initial License for Current Owners: 08/01/00

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven M. Kroll **Telephone Number:** (773) 286-3883

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Joan Carl
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Alden Park Strathmoor # 0044909 Report Period Beginning: 1/1/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	189	Skilled (SNF)	189	69,174	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	189	TOTALS	189	69,174	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,340	1,430	2,703	16,473	8
9	SNF/PED					9
10	ICF	25,656	330	214	26,200	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,996	1,760	2,917	42,673	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.69%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 8/1/00

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 8/1/00 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 71 and days of care provided 2,302

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Alden Park Strathmoor # 0044909 **Report Period Beginning:** 1/1/04 **Ending:** 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	263,578	26,413	9,100	299,091	1,193	300,284		300,284			1
2	Food Purchase		295,956		295,956	(17,296)	278,660	(42,357)	236,303			2
3	Housekeeping	196,815	32,500		229,315	998	230,313		230,313			3
4	Laundry	79,460	37,971		117,431	485	117,916		117,916			4
5	Heat and Other Utilities			139,182	139,182		139,182	(32)	139,150			5
6	Maintenance	39,356		76,611	115,967		115,967	6,521	122,488			6
7	Other (specify):* **Related Party Salary**							31,558	31,558			7
8	**TOTAL General Services**	579,209	392,840	224,893	1,196,942	(14,620)	1,182,322	(4,310)	1,178,012			8
	B. Health Care and Programs											
9	Medical Director			26,000	26,000		26,000		26,000			9
10	Nursing and Medical Records	2,230,194	119,625	77,737	2,427,556	4,169	2,431,725	(95,323)	2,336,402			10
10a	Therapy	126,998			126,998		126,998		126,998			10a
11	Activities	47,704	2,582	5,161	55,447	64	55,511		55,511			11
12	Social Services	36,095			36,095		36,095		36,095			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* **Related Party Salary**							23,599	23,599			15
16	**TOTAL Health Care and Programs**	2,440,991	122,207	108,898	2,672,096	4,233	2,676,329	(71,724)	2,604,605			16
	C. General Administration											
17	Administrative	52,639		93,443	146,082		146,082		146,082			17
18	Directors Fees											18
19	Professional Services			400,148	400,148		400,148	(362,171)	37,977			19
20	Dues, Fees, Subscriptions & Promotions			22,970	22,970		22,970	(7,993)	14,977			20
21	Clerical & General Office Expenses	100,047	18,664	133,196	251,907	234	252,141	(84,799)	167,342			21
22	Employee Benefits & Payroll Taxes			598,222	598,222	10,153	608,375	698	609,073			22
23	Inservice Training & Education											23
24	Travel and Seminar			18,041	18,041		18,041	10,190	28,231			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			165,001	165,001		165,001	6,629	171,630			26
27	Other (specify):* **Related Party Salary**			149,269	149,269		149,269	136,388	285,657			27
28	**TOTAL General Administration**	152,686	18,664	1,580,290	1,751,640	10,387	1,762,027	(301,058)	1,460,969			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,172,886	533,711	1,914,081	5,620,678		5,620,678	(377,092)	5,243,586			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Alden Park Strathmoor #0044909 Report Period Beginning: 1/1/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			30,082	30,082		30,082	233,952	264,034			30
31	Amortization of Pre-Op. & Org.							1,351	1,351			31
32	Interest			71,469	71,469		71,469	189,343	260,812			32
33	Real Estate Taxes							107,908	107,908			33
34	Rent-Facility & Grounds			335,915	335,915		335,915	(334,701)	1,214			34
35	Rent-Equipment & Vehicles			6,985	6,985		6,985	17,105	24,090			35
36	Other (specify):*											36
37	**TOTAL Ownership**			444,451	444,451		444,451	214,958	659,409			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	263,933	297,868	547,528	1,109,329		1,109,329	(136,034)	973,295			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			103,762	103,762		103,762		103,762			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	263,933	297,868	651,290	1,213,091		1,213,091	(136,034)	1,077,057			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,436,819	831,579	3,009,822	7,278,220		7,278,220	(298,168)	6,980,052			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Reporting Period Beginning 1/01/04
Reporting Period Ending 12/31/04

Reclassifications - Pgs 3 and 4

From Line	To Line	Amount	Description
2		(17,296)	Employee Meal
	22	17,296	Employee Meal
22		(7,143)	Uniforms
	1	1,193	Uniforms
	3	998	Uniforms
	4	485	Uniforms
	10	4,169	Uniforms
	11	64	Uniforms
	21	234	Uniforms
			Uniforms
		0	Net should be 0

Facility Name & ID Number Alden Park Strathmoor # 0044909 Report Period Beginning: 1/1/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,186)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,084)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(10,207)	21		17
18	Fines and Penalties	(14,855)	32		18
19	Entertainment	(69)	20		19
20	Contributions	(907)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,169)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(149,269)	27		24
25	Fund Raising, Advertising and Promotional	(4,184)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (182,930)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(58,653)	Various	34
35	Other- Attach Schedule	(56,585)	Page 5A	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (115,238)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (298,168)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Alden Park Strathmoor

ID# 0044909

Report Period Beginning: 1/1/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Late fees on utilities	$ (2,371)	5	1
2	Vending machine income	(132)	2	2
3	Other nursing income (flu, blood, gluc,wh chr., etc)	1,068	21	3
4	Intercompany interest	(16,261)	32	4
5	Intercompany interest	(3)	32	5
6	Back out pac 31.78% of IHCA dues	(3,243)	20	6
7	Back out prior year vendor settlements	4,138	21	7
8	Park S. LLC - Interco. Int to Rockford Inv.	(8,000)	32	8
9	Park S. LLC - Interco. Int to AMS	(29,550)	32	9
10	Adj deprec exp to correct amount	(2,345)	30	10
11	Back out LLC NSF Bank Fees	(100)	19	11
12	Back out legal collections - Aaby	(1,389)	19	12
13	Back out 2003 voided invoices	1,478	19	13
14	Back out legal collections - Fisch	125	19	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(56,585)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Park Strathmoor # 0044909 Report Period Beginning: 1/1/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,216)	0	0	(41,141)	0	0	0	0	0	0	0	(42,357)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(2,371)	0	2,339	0	0	0	0	0	0	0	0	(32)	5
6	Maintenance	0	0	6,985	0	0	0	(11)	(453)	0	0	0	6,521	6
7	Other (specify):*	0	0	31,558	0	0	0	0	0	0	0	0	31,558	7
8	**TOTAL General Services**	(3,587)	0	40,882	(41,141)	0	0	(11)	(453)	0	0	0	(4,310)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(89,941)	(5,382)	0	0	0	0	0	0	(95,323)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	23,599	0	0	0	0	0	0	0	0	23,599	15
16	**TOTAL Health Care and Programs**	0	0	23,599	(89,941)	(5,382)	0	0	0	0	0	0	(71,724)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,055)	1,776	(362,892)	0	0	0	0	0	0	0	0	(362,171)	19
20	Fees, Subscriptions & Promotions	(8,403)	0	410	0	0	0	0	0	0	0	0	(7,993)	20
21	Clerical & General Office Expenses	(5,001)	(155,155)	26,479	46,373	2,505	0	0	0	0	0	0	(84,799)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	698	0	0	0	0	0	0	698	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	10,190	0	0	0	0	0	0	0	0	10,190	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	6,404	225	0	0	0	0	0	0	0	0	6,629	26
27	Other (specify):*	(149,269)	0	271,596	10,878	3,183	0	0	0	0	0	0	136,388	27
28	**TOTAL General Administration**	(163,728)	(146,975)	(53,992)	57,251	6,386	0	0	0	0	0	0	(301,058)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(167,315)	(146,975)	10,489	(73,831)	1,004	0	(11)	(453)	0	0	0	(377,092)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Alden Park Strathmoor** **#** **0044909** **Report Period Beginning:** **1/1/04** **Ending:** **12/31/04**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(2,345)	225,755	9,144	0	1,398	0	0	0	0	0	0	233,952	30
31	Amortization of Pre-Op. & Org.	0	0	1,351	0	0	0	0	0	0	0	0	1,351	31
32	Interest	(69,855)	218,691	38,328	0	180	1,999	0	0	0	0	0	189,343	32
33	Real Estate Taxes	0	102,134	5,603	0	171	0	0	0	0	0	0	107,908	33
34	Rent-Facility & Grounds	0	(335,915)	1,214	0	0	0	0	0	0	0	0	(334,701)	34
35	Rent-Equipment & Vehicles	0	0	17,105	0	0	0	0	0	0	0	0	17,105	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(72,200)	210,665	72,745	0	1,749	1,999	0	0	0	0	0	214,958	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(10,278)	(12,689)	(113,067)	0	0	0	0	0	(136,034)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	(10,278)	(12,689)	(113,067)	0	0	0	0	0	(136,034)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(239,515)	63,690	83,234	(84,109)	(9,936)	(111,068)	(11)	(453)	0	0	0	(298,168)	45

Facility Name & ID Number Alden Park Strathmoor # 0044909 Report Period Beginning: 1/1/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See pg. 6L						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income	$ 335,915	Park Strathmoor, LLC	0.00%	$	$ (335,915)	1
2	V	32	Interest Exp to Rockford, LLC		Park Strathmoor, LLC		8,000	8,000	2
3	V	32	Interest Exp to AMS		Park Strathmoor, LLC		29,550	29,550	3
4	V	19	Misc. Admin Expense		Park Strathmoor, LLC		1,776	1,776	4
5	V	33	Real Estate Tax		Park Strathmoor, LLC		102,134	102,134	5
6	V	26	Property & Liability Insur		Park Strathmoor, LLC		6,404	6,404	6
7	V	32	Interest On Mortg. Note		Park Strathmoor, LLC		181,141	181,141	7
8	V	30	Depreciation		Park Strathmoor, LLC		225,755	225,755	8
9	V	21	Vendor Settlements		Park Strathmoor, LLC		(155,155)	(155,155)	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 335,915			$ 399,605	$ * 63,690	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Park Strathmoor # 0044909 Report Period Beginning: 1/1/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional fees	$ 371,169	Alden Management Services	0.00%	$ 8,277	$ (362,892)	15
16	V	21	Clerical and G & A		Alden Management Services		26,479	26,479	16
17	V	5	Utilities		Alden Management Services		2,339	2,339	17
18	V	6	Maintenance		Alden Management Services		6,985	6,985	18
19	V	24	Travel & seminar		Alden Management Services		10,190	10,190	19
20	V	26	Insurance		Alden Management Services		225	225	20
21	V	20	Dues/subscriptions/fees etc		Alden Management Services		410	410	21
22	V	30	Depreciation		Alden Management Services		9,144	9,144	22
23	V	31	Amortization		Alden Management Services		1,351	1,351	23
24	V	33	Real estate taxes		Alden Management Services		5,603	5,603	24
25	V	34	Rent-facilities		Alden Management Services		1,214	1,214	25
26	V	35	Rent-equipment/vehicles		Alden Management Services		17,105	17,105	26
27	V	32	Interest		Alden Management Services		38,328	38,328	27
28	V	7	Salaries-general serv		Alden Management Services		31,558	31,558	28
29	V	15	Salaries-health care		Alden Management Services		23,599	23,599	29
30	V	27	Salaries-general admin		Alden Management Services		271,596	271,596	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 371,169			$ 454,403	$ * 83,234	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Park Strathmoor # 0044909 Report Period Beginning: 1/1/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Tube Feeding	$ 90,955	Pyramid Health Care	0.00%	$ 49,814	$ (41,141)	15
16	V	10	Nursing Supply	105,116	Pyramid Health Care		15,175	(89,941)	16
17	V	39	Per Diems/Other Supplies	23,360	Pyramid Health Care		13,082	(10,278)	17
18	V	21	General & Admin		Pyramid Health Care		46,373	46,373	18
19	V	27	General & Admin Salaries		Pyramid Health Care		10,878	10,878	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 219,431			$ 135,322	$ * (84,109)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Park Strathmoor # 0044909 Report Period Beginning: 1/1/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Drugs	$ 55,626	Forum Extended Care II	0.00%	$ 47,979	$ (7,647)	15
16	V	10	House Stock	3,334	Forum Extended Care II		2,876	(458)	16
17	V	39	IV	36,678	Forum Extended Care II		31,636	(5,042)	17
18	V	22	Employee Benefits		Forum Extended Care II		698	698	18
19	V	21	G & A		Forum Extended Care II		2,505	2,505	19
20	V	32	Interest		Forum Extended Care II		180	180	20
21	V	33	Real Estate Taxes		Forum Extended Care II		171	171	21
22	V	30	Depreciation		Forum Extended Care II		1,398	1,398	22
23	V	27	General & Admin Salaries		Forum Extended Care II		3,183	3,183	23
24	V	10	Pharmacy Consulting	4,924	Forum Extended Care II			(4,924)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 100,562			$ 90,626	$ * (9,936)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Park Strathmoor # 0044909 Report Period Beginning: 1/1/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy	$ 542,089	Community Physical Therapy	0.00%	$ 429,022	$ (113,067)	15
16	V	32	Interest		Community Physical Therapy		1,999	1,999	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 542,089			$ 431,021	$ * (111,068)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Park Strathmoor # 0044909 Report Period Beginning: 1/1/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		6	Maintenance Expense	$ 7,567	Alden Bennett Construction	0.00%	$ 7,556	$ (11)	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 7,567			$ 7,556	$ * (11)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Park Strathmoor # 0044909 Report Period Beginning: 1/1/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		6	Carpet Cleaning	$ 215	Alden Realty - Carpet Care	0.00%	$ 192	$ (23)	15
16	V		6	Floor Cleaning	4,410	Alden Realty - Floor Care		3,980	(430)	16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 4,625			$ 4,172	$ * (453)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ALDEN NURSING CENTER - PARK STRATMOOR # 42010 Report Period Beginning 01/01/04 Ending: 12/31/04

RELATED NURSING HOMES	
Name	City
Note: ANC = Alden Nursing Center	
ANC Lakeland	Chicago
ANC Long Grove	Long Grove
ANC Heather	Harvey
ANC Lincoln Park	Chicago
ANC Northmoor	Chicago
ANC Town Manor	Chicago
ANC Terrace of McHenry	McHenry
ANC Morrow	Chicago
ANC Wentworth	Chicago
ANC Naperville	Naperville
ANC Valley Ridge	Bloomingdale
ANC Village for Children & Young Adults	Bloomingdale
ANC Orland Park	Orland Park
ANC Princeton	Chicago
Alden of Old Town East	Bloomingdale
Alden of Old Town West	Bloomingdale
Alden Trails	Bloomingdale
Alden Northshore	Skokie
ANC Des Plaines	Des Plaines
ANC Des Plaines II	Des Plaines
ANC Waterford	Aurora
ANC Park Stratmoor	Rockford
ANC Meadow Park	Rockford
ANC Poplar Creek	Hoffman Estates
ANC Governer's Park of Barrington	Barrington
ANC Gardens of Rockford	Rockford

OTHER RELATED BUSINESS ENTITIES		
Name	City	Type of Business
The Forum Prof. Center	Chicago	Office rental
Pyramid Health Care	Chicago	Nursing supplies
Forum Extended Care II	Chicago	Pharmacy
Alden Management	Chicago	Management
Alden Estates of Evanston	Evanston	Assisted living
Community Physical Therapy	Wood Dale	Therapy provider
Courts of Waterford	Aurora	Alzheimers unit
Gardens of Waterford	Aurora	Assisted living

Facility Name & ID Number ALDEN NURSING CENTER - PARK STRATHMOOR # 32730 Report Period Beginning 01/01/03 Ending: 12/31/04

Nursing Home Owners	
Name	% Ownership
Note: ANC = Alden Nursing Center	
Alden Rockford Investments, LLC	100%

Facility Name & ID Number Alden Park Strathmoor # 0044909 Report Period Beginning: 1/1/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd Schlossberg a.	President	CEO	100.00	219,244	1.496	3.74	salary	$ 8,520	27-7	1
2											2
3											3
4	Lauren Magnusson b.	Nurse corrdinator	Nursing admin		70,798	1.496	3.74	salary	2,751	15-7	4
5	Terry Magnusson c.	Maint. Supervisor	Constr/maint		48,130	1.496	3.74	salary	1,870	7-7	5
6											6
7											7
8											8
9	a. Floyd is the President and sole stockholder of The Alden Group, Ltd.										9
10	b. Lauren is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator										10
11	c. Terry is the son-in-law of Floydd Schlossberg. Terry is in maintenance and construction.										11
12											12
13								TOTAL	$ 13,141		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Park Strathmoor # 0044909 Report Period Beginning: 1/1/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Alden Management Services, Inc.
Street Address: 4200 W. Peterson Ave.
City / State / Zip Code: Chicago, IL 60646
Phone Number: (773-286-3883
Fax Number: (773-286-3473

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		See Page 8A (also on Page 6A)				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Alden Park Strathmoor # 0044909 Report Period Beginning: 1/1/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank Leumi		X	Line of Credit	Interest Only	01/04	$ 750,000	$ 750,000	Varies		$ 40,147	1
2	Bank Leumi		X	Mortgage	$23,870.00	10/04	3,400,000	3,378,313	03/06		174,800	2
3	National City Bank		X	Mortgage	Interest Only	8/1/00	3,480,000	zero	Varies		6,341	3
4	National City Bank		X	Line of Credit	Interest Only	8/1/00		zero	Varies		203	4
5												5
	Working Capital											
6	Related Party - AMS	X		Working Capital							38,328	6
7	Related Party - FECII	X		Working Capital							180	7
8	Related Party - CPT	X		Working Capital							1,999	8
9	TOTAL Facility Related				$23,870.00		$ 7,630,000	$ 4,128,313			$ 261,998	9
	B. Non-Facility Related*											
10	Offset Int. exp w/ int inc.										(1,186)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,186)	14
15	TOTALS (line 9+line14)						$ 7,630,000	$ 4,128,313			$ 260,812	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Alden Park Strathmoor # 0044909 Report Period Beginning: 1/1/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	101,422	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	100,256	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,166)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	103,300	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	102,134	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000	92,548	9
2001	97,015	10
2002	99,433	11
2003	101,008	12

Accrual based on 3% increase over prior year bill.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden Park Strathmoor COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0044909

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE 773-286-3883 FAX #: 773-286-3743

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-21-452-007	Nursing home facility	$ 100,256.00	$ 100,256.00
2.		Related Party - Alden Management	$ 149,765.00	$ 5,603.00
3.		Related Party - Forum	$ 13,827.00	$ 171.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 263,848.00	$ 106,030.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Alden Park Strathmoor # 0044909 Report Period Beginning: 1/1/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 49,906 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home			$ 569,205	1
2					2
3	TOTALS			$ 569,205	3

Facility Name & ID Number Alden Park Strathmoor # 0044909 Report Period Beginning: 1/1/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	189		2000		$ 3,604,967	$ 114,443	31.5	$ 114,443	$	$ 505,458	4
5											5
6											6
7											7
8	Related Party - Forum			1978	16,213		22			16,213	8
	Improvement Type**										
9	Alden Design-laundry room remodeling			2000	3,922	392	10	392		1,700	9
10	Alden Design-laundry room remodeling			2000	2,098	210	10	210		909	10
11	Alden Design-laundry room remodeling			2000	4,533	453	10	453		1,927	11
12	ABC - misc const. Work			2000	1,561	312	5	312		1,301	12
13	Pro Com Systems - add new keypass to alarm system			2000	1,754	351	5	351		1,433	13
14	ABC - misc const. Work			2001	10,528	526	20	526		1,667	14
15	ABC - misc const. Work			2001	38,850	1,943	20	1,943		6,151	15
16	Rockford stem B			2001	5,035	336	15	336		1,231	16
17	FE Moran - Repair and Upgrade fire alarm system			2002	7,645	510	15	510		1,359	17
18	Patten - Repair Water System			2002	2,245	150	15	150		424	18
19	Capps - Repair water sys in Kitchen			2002	2,845	190	15	190		427	19
20	ABC - Repair Water heater			2002	7,113	474	15	474		1,304	20
21	ABC -			2002	4,256	284	15	284		591	21
22	ABC (misc construction work)			2002	4,233	423	10	423		882	22
23	ABC - Carpet			2002	1,078	108	10	108		297	23
24	ABC - Chimney			2002	758	38	20	38		85	24
25	ABC - Chimney 2			2002	3,032	152	20	152		341	25
26	GT Mech - Repair Cooler			2003	4,586	917	5	917		1,376	26
27	CSI Coker - Repair Freezer			2003	1,645	329	5	329		493	27
28	GT Mech - Repair AC			2003	1,648	165	10	165		247	28
29	GT Mech - Repair Refrigerator			2003	1,860	372	5	372		527	29
30	Simplex - Fire & Security System Repair			2003	1,986	132	15	132		176	30
31	Simplex - Fire & Security System Repair			2003	896	60	15	60		90	31
32	ABC - Repairs to Dining room			2003	5,177	518	10	518		604	32
33	ABC - Repair Boiler			2003	4,311	431	10	431		467	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Alden Park Strathmoor # 0044909 Report Period Beginning: 1/1/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	GT Mechanical-a/c repair	2004	$ 2,996	$ 150	10	$ 150	$	$ 150	37
38	GT Mechanical-repair hot water tank	2004	3,325	83	10	83		83	38
39	P&M Mercury-chiller repair	2004	2,118	71	10	71		71	39
40	ABC-electrical & plumbing repairs	2004	2,112	53	10	53		53	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,755,324	$ 124,576		$ 124,576	$	$ 548,037	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Park Strathmoor # 0044909 Report Period Beginning: 1/1/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,755,324	$ 124,576		$ 124,576	$	$ 548,037	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,755,324	$ 124,576		$ 124,576	$	$ 548,037	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Park Strathmoor # 0044909 Report Period Beginning: 1/1/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,755,324	$ 124,576		$ 124,576	$	$ 548,037	1
2									2
3	Related Party-Forum:								3
4	Leasehold Improvement-Remodeling	1980	12,303		15			12,303	4
5	Leasehold Improvement-Remodeling	1980	19,273		20			19,273	5
6	Leasehold Improvement-Tenant Improvement	1987	996		13			996	6
7	Leasehold Improvement-AMS Remodel	1988	14,339		10			14,339	7
8	Leasehold Improvement-Roof	1994	3,572	223	16	223		2,234	8
9	Leasehold Improvement-Build.Improv.	1996	1,259	79	16	79		704	9
10	Leasehold Improvement-Asphalting	2000	98		3			98	10
11	Leasehold Improvement-DAI	2001	172	17	10	17		54	11
12	Leasehold Improvement-Bathrooms	2002	733	82	7	82		181	12
13	Leasehold Improvement-Suite Renovation	2003	1,638	164	10	164		328	13
14	Leasehold Improvement-Plumbing, Construct, Concrete, Doors, etc	2004	1,820	148	7	148		148	14
15	Leasehold Improvement-Add-on Improvement, fixture base	1980	79		23			79	15
16	Leasehold Improvement-Add-on Improvement, lighting base	2001	137	27	5	27		103	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26	Related Party-AMS:								26
27	Leasehold Improvement-Remodeling	1993	5,938		7			5,938	27
28	Leasehold Improvement-Remodeling	2002	4,861	608	7	608		1,215	28
29	Leasehold Improvement-Remodeling	2003	5,085	775	7	775		1,394	29
30									30
31									31
32									32
33	Forum Extended Care, LLC-building/building improv	1999	13,393	266	30	266		2,041	33
34	TOTAL (lines 1 thru 33)		$ 3,841,020	$ 126,965		$ 126,965	$	$ 609,466	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Park Strathmoor # 0044909 Report Period Beginning: 1/1/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 777,163	$ 131,052	$ 131,052	$	Various	$ 544,563	71
72	Current Year Purchases	16,665	4,409	4,409		Various	4,409	72
73	Fully Depreciated Assets	47,882	1,478	1,478		Various	47,882	73
74								74
75	TOTALS	$ 841,710	$ 136,939	$ 136,939	$		$ 596,854	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Car Engine/Bus/Van	Various / Dodge	98-'04	$ 8,164	$ 130	$ 130	$	3	$ 7,981	76
77										77
78										78
79										79
80	TOTALS			$ 8,164	$ 130	$ 130	$		$ 7,981	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,260,099	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 264,034	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 264,034	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,214,301	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	none	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$ n/a	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Related party - cost is backed out

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ Related party, cost is eliminated			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 2,489 Description: copy machine $593 postage meter $1,896
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	non-patient transport		$ 562.00	$ 4,496	17
18	Related Party - AMS		1,425.00	17,105	18
19					19
20					20
21	TOTAL		$ 1,987.00	$ 21,601	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Alden Park Strathmoor # 0044909 Report Period Beginning: 1/1/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [x] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

Skilled Nurses On Site

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 44,583	$		$ 44,583	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			27,669			27,669	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			168,358			168,358	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See Pg 16 A	# of prescrpts				42,938		42,938	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	See Pg 16 A		263,933		25,055	37,579		326,567	12
13	Other (specify): Vent Dependant	See Pg 16 A				(113,067)	476,225		363,158	13
14	TOTAL			$ 263,933		$ 152,598	$ 556,742		$ 973,273	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

			Page 16 Col 5: PT,OT, & ST Col 6: Other Amount
XIV. SPECIAL SERVICES (Direct Cost)			
Service			
1. OT	39-3		$44,582.99
2. ST	39-3		27,669.02
3.			
4. PT	39-3		168,357.95
5.			
6.			
7.			
8.			
9. Phamacy	See pg 16		55,625.85
Plus: Related Party- Forum Drugs			(7,646.00)
Plus: Related Party- Forum I.V.			(5,042.00)
Total to line 9 Pharmacy			42,937.85
10.			
11.			
12. Exceptional Care-Column 3	See pg 16		263,933.00
12. Exceptional Care-Column 5	See pg 16		25,077.00
12. Exceptional Care-Column 6	See pg 16		37,579.38
13. Other : Lab, X-Ray Therapy, Mattress, Pyramid Billings		See pg 16	448,262.35
Oxygen Cost - IDPA			38,241.00
Related Party- Pyramid			(10,278.00)
Related Party- CPT			(113,067.00)
Total to line 13			363,158.35
14. Total			973,295.54

Facility Name & ID Number Alden Park Strathmoor **#** 0044909 **Report Period Beginning:** 1/1/04 **Ending:** 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/04 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 147,879	$ 148,057	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (130,000))	1,454,042	1,454,042	3
4	Supply Inventory (priced at)	1,112	1,112	4
5	Short-Term Investments			5
6	Prepaid Insurance		3,126	6
7	Other Prepaid Expenses	2,544	2,544	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due From 3rd Parties	9,413	9,413	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,614,990	$ 1,618,294	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		569,205	13
14	Buildings, at Historical Cost		3,604,967	14
15	Leasehold Improvements, at Historical Cost	145,525	145,525	15
16	Equipment, at Historical Cost	206,680	763,236	16
17	Accumulated Depreciation (book methods)	(80,169)	(1,077,252)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		113,981	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(1,568)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP Land	1,637	1,637	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 273,673	$ 4,119,731	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,888,663	$ 5,738,025	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,079,414	$ 1,107,264	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	88,303	88,303	28
29	Short-Term Notes Payable	750,000	750,000	29
30	Accrued Salaries Payable	318,885	318,885	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,931	23,931	31
32	Accrued Real Estate Taxes(Sch.IX-B)		103,300	32
33	Accrued Interest Payable		16,658	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accr Ins,Exps,IDPA,Sales Tax, etc.	76,312	79,438	36
37	Due to Owners & Affiliates	4,399,345	5,605,690	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,736,190	$ 8,093,469	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,378,313	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 3,378,313	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,736,190	$ 11,471,782	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,847,527)	$ (5,733,757)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,888,663	$ 5,738,025	48

***(See instructions.)**

Facility Name & ID Number Alden Park Strathmoor # 0044909 Report Period Beginning: 1/1/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,733,351)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,733,351)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,114,176)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (2,114,176)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (4,847,527)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Alden Park Strathmoor # 0044909 Report Period Beginning: 1/1/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,646,822	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,646,822	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	278,659	6
7	Oxygen	144,571	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 423,230	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	676	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	8,515	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,159	19
20	Radiology and X-Ray		20
21	Other Medical Services	41,758	21
22	Laundry	289	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 54,397	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,186	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,186	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Pg 19 A	38,409	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 38,409	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,164,044	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,196,942	31
32	Health Care	2,672,096	32
33	General Administration	1,751,640	33
	B. Capital Expense		
34	Ownership	444,451	34
	C. Ancillary Expense		
35	Special Cost Centers	1,109,329	35
36	Provider Participation Fee	103,762	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,278,220	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,114,176)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,114,176)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Yet Done If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

For the Thirteen Months Ending December 31, 2004

Page 19A

Must be submitted if there is a balance on Line 28. You need only report the info that has a balance.

	Column 1 Amount	
Vending Machine Income (is offset againts line 2, Schdl V.)	132.15	
Miscellaneous Income gl 4977 (describe) (is offset againts Schdl V.)	2,512.10	Various- all under $2k
Recovery of Bad Debts (private only, is not offset on Schld V)	22,933.46	
Write Off of Old Amounts Due (related to prior yr, not offset on Schdl V)	12,831.73	
Total of line 28	38,409.44	

Facility Name & ID Number Alden Park Strathmoor # 0044909 Report Period Beginning: 1/1/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	501	501	$ 13,151	$ 26.25	1
2	Assistant Director of Nursing	1,244	1,309	46,974	35.89	2
3	Registered Nurses	18,019	18,523	582,724	31.46	3
4	Licensed Practical Nurses	32,281	33,349	799,144	23.96	4
5	Nurse Aides & Orderlies	75,183	80,164	943,039	11.76	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,273	4,579	70,546	15.41	8
9	Activity Director	480	480	7,071	14.73	9
10	Activity Assistants	4,933	5,115	44,816	8.76	10
11	Social Service Workers	1,992	2,080	36,095	17.35	11
12	Dietician					12
13	Food Service Supervisor	2,005	2,045	29,187	14.27	13
14	Head Cook	400	546	7,324	13.41	14
15	Cook Helpers/Assistants	22,783	24,401	227,067	9.31	15
16	Dishwashers					16
17	Maintenance Workers	2,032	2,080	39,356	18.92	17
18	Housekeepers	20,313	21,741	196,815	9.05	18
19	Laundry	8,206	8,456	79,460	9.40	19
20	Administrator	792	875	28,409	32.47	20
21	Assistant Administrator	928	1,008	24,231	24.04	21
22	Other Administrative	3,574	3,683	61,583	16.72	22
23	Office Manager					23
24	Clerical	4,251	4,371	38,464	8.80	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,233	2,257	58,520	25.93	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Clinical Support S	2,638	2,756	56,452	20.48	32
33	Other(specify) Alzheimers staff	5,082	5,213	46,391	8.90	33
34	TOTAL (lines 1 - 33)	214,143	225,532	$ 3,436,819 *	$ 15.24	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 9,100	1-3	35
36	Medical Director	Monthly	26,000	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,536	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	45	2,432	11-3	44
45	Social Service Consultant	12	668	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	57	$ 42,736		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ n/a		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Alden Park Strathmoor # 0044909 Report Period Beginning: 1/1/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Judy Wright	Administrator		$ 28,409
Kelly Gregory	Asst. Administrator		24,230
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 52,639

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
AMS	Management Fees	$ 370,992
BDO Seidman	Accounting Fees	5,933
Neal Gerber/KPMG/Trimble&Jewel	Legal Fees	474
Williams & McCarthy	Consulting Services	1,865
David Aaby	Legal Fees	1,718
Jennings Law / Dana Cons.	401k services	530
Medi.Com	Billing Consultants	446
Arthur Swanson	Legal Fees	500
National City	Renew loan-voided 2003	(1,451)
Ken Fisch	Legal Fees	16,951
Barry Greenburg	Legal Fees	2,013
misposted copier lease exp		177
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 400,148

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 82,661
Unemployment Compensation Insurance	9,542
FICA Taxes	377,560
Employee Health Insurance	21,691
Employee Meals	17,296
Illinois Municipal Retirement Fund (IMRF)*	
Union Health & Welfare	70,015
Dental, Life, Relations, Misc	2,336
Drug Test & Employee Dishonesty	2,491
401k Match, Vaccinations, Other	744
Related Party - Forum	698
Related Party - AMS	
Pension	24,039
TOTAL (agree to Schedule V, line 22, col.8)	$ 609,073

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,513
Health Care Worker Background Check	462
(Indicate # of checks performed 66)	
Surety Bond Fees, Dues & Subscriptions	2,629
Il Health Care Assoc.	6,963
Related Party - AMS	410
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,977

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Gas / Mileage	1,068
Related Party - AMS	10,190
Rockford Area Meeting	16,623
Seminar Expense	
Alzheimer's Association seminar	350
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 28,231

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Alden Park Strathmoor # 0044909 Report Period Beginning: 1/1/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	Alden Design	10/00	$ 1,669	3	$ 556	$ 556	$ 418	$	$	$	$	$	$
2	Rockford stemm B	5/01	1,735	3	385	578	578	193					
3	Alden Bennet Const	2/01	7,975	3	2,436	2,658	2,658	221					
4	No Additions '02-'04												
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 11,379		$ 3,377	$ 3,792	$ 3,654	$ 414	$	$	$	$	$

Facility Name & ID Number Alden Park Strathmoor # 0044909 Report Period Beginning: 1/1/04 Ending: 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Healthcare Assoc. $10,206**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,712** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **103,762**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **17,296** Has any meal income been offset against related costs? **No** Indicate the amount. $ **n/a**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **n/a**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **n/a**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain. **Not Required**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.